The 'Right to Die': On Drawing (and Erasing) Lines

Yale Kamisar

University of Michigan Law School, ykamisar@umich.edu

Follow this and additional works at: http://repository.law.umich.edu/articles

Part of the Courts Commons, Fourteenth Amendment Commons, Medical Jurisprudence Commons, Privacy Law Commons, and the Supreme Court of the United States Commons

Recommended Citation


This Article is brought to you for free and open access by the Faculty Scholarship at University of Michigan Law School Scholarship Repository. It has been accepted for inclusion in Articles by an authorized administrator of University of Michigan Law School Scholarship Repository. For more information, please contact mlaw.repository@umich.edu.
The "Right to Die": On Drawing (and Erasing) Lines

Yale Kamisar*

"Some of the Court's unacceptable lines just happen. To avoid difficult questions, to support a result dictated by intuition or sympathy, perhaps to achieve a majority for that result, the Justices seize a rationale that comes to mind, without asking where it leads and whether they are prepared to go there."¹

Until this year, no state or federal appellate court had ever held that there was a right to assisted suicide no matter how narrow the circumstances or stringent the conditions.² In 1996, however, within the span of a single month, two federal courts of appeals so held; in an 8-3 majority of the Ninth Circuit (sitting en banc) in Compassion in Dying v. Washington³ and a three-judge panel of the Second Circuit in Quill v. Vacco.⁴

---

* Clarence Darrow Distinguished University Professor of Law, University of Michigan.

² The only state supreme court to address this issue up to now has been the Michigan Supreme Court. The Michigan Court held that there was no right to, or liberty interest in, assisted suicide protected by the Fourteenth Amendment and explicitly rejected Judge Barbara Rothstein's analysis in Compassion in Dying v. Washington, 850 F. Supp. 1454 (W.D. Wash. 1994). In Compassion in Dying, Judge Rothstein became the first federal district court judge to strike down a statute outlawing assisted suicide on Due Process grounds when she invalidated Washington's law insofar as it placed an undue burden on competent, terminally ill adults who sought physician-assisted suicide. Judge Rothstein's decision was reversed by a panel of the Ninth Circuit. Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995) (2-1 decision; Noonan, J.). The following year, however, the panel decision was vacated and Judge Rothstein's opinion affirmed by an 8-3 majority of the Ninth Circuit, sitting en banc. See Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) en banc, cert. granted sub nom. Washington v. Glucksberg, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). The en banc opinion by Judge Stephen Reinhardt is a principal subject of this article. This author shall refer to the opinion as the Compassion in Dying case, the Compassion in Dying court, the Compassion in Dying majority or the Ninth Circuit opinion (after all, Judge Reinhardt did write for seven other judges as well as for himself).
⁴ 80 F.3d 716 (2d Cir. 1996) (Miner, J.), cert. granted, Vacco v. Quill, 65 U.S.L.W. 3254 (U.S. Oct. 1, 1996) (No. 95-1858). Although there was no dissent, Judge Guido Calabresi did not join the majority opinion and wrote a separate opinion concurring in the result. Judge Calabresi's opinion is discussed at considerable length elsewhere in this
What heartened proponents of a right to physician-assisted suicide even more, and pleased those resistant to the idea even less, was that the two courts which found a constitutional right in assisted-suicide did so by invoking different provisions of the Fourteenth Amendment. The Ninth Circuit relied on the Due Process Clause and the Second Circuit turned to the Equal Protection Clause.  

The *Compassion in Dying* majority concluded first that "there is a constitutionally-protected liberty interest in determining the time and manner of one's own death." This individual interest must be weighed against the state's countervailing interests, such as the state's general interest in preserving life, its more specific interest in preventing suicide, and its interest in protecting the integrity of the medical profession. After balancing the competing interests, and emphasizing that the state's interest in preserving life and preventing suicides is "substantially diminished in the case of terminally ill, competent adults who wish to die," the Ninth Circuit arrived at its next conclusion: Insofar as the Washington statute totally banning assisted suicide "prohibits physicians from prescribing life-ending medication for use by

---


5. Opponents of a right to, or liberty interest in, assisted suicide, however, gained some comfort from the fact that before proceeding to an Equal Protection analysis, the Second Circuit rejected the plaintiff’s "Due Process and fundamental rights argument." The Second Circuit noted: 

[...]he right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that [the claimed right] is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true.

*Quill*, 80 F.3d at 724. Although the district court in the *Compassion in Dying* case had invalidated the Washington statute on the basis that it violated the Equal Protection Clause, as well as on Due Process grounds, the *en banc* opinion of the Ninth Circuit does not consider the Equal Protection issue and observes that "[o]ne constitutional violation is enough" to support its judgment. *Compassion in Dying*, 79 F.3d at 838. The *Compassion in Dying* majority did say, however, that the Equal Protection argument relied on by the district court "is not insubstantial." *Id.* at 838 n.139.

6. *Compassion in Dying*, 79 F.3d at 793.

7. *See id.* at 789, 816-32.

8. *Id.* at 820. Assuming arguendo that this is so, what about the weight of the individual's liberty interest in "hastening his or her death"? Consider, for example, a competent, well-informed quadriplegic who has twenty or thirty years more to live and to endure what he or she considers to be a dismal, miserable existence. Assume, further, that this person has a persistent wish to die by suicide with the aid of a physician rather than live out an intolerable existence. Doesn't this person have a more weighty liberty interest in "hastening his or her death," for example, dying by physician-assisted suicide, than a terminally ill patient who need only endure two or three months (or weeks) of an existence this patient deems intolerable? *See also* text at infra notes 128-31.
1996 The "Right to Die": On Drawing and Erasing Lines 483
terminally ill, competent adults who wish to hasten their own
deaths, it violates the Due Process Clause.9

Although the Ninth Circuit found support for its conclusions in
Cruzan v. Director, Missouri Department of Health,10 which is so
far the only case on death, dying and the "right of privacy"
decided by the U.S. Supreme Court, the court's reliance on this
case is dubious. The Cruzan Court did not need to and did not
discuss the right or liberty interest in determining the time and
manner of one's death, hastening one's death, or obtaining the
active intervention of a physician to help bring about one's sui-
cide. The only assumption that the Cruzan court made for pur-
oposes of that case was that a competent person had a
constitutionally protected interest in refusing unwanted life-sus-
taining medical treatment (even artificially delivered food and
water).11

9. Compassion in Dying, 79 F.3d at 793. In the course of its long opinion, the
Ninth Circuit relied heavily on Roe v. Wade, 410 U.S. 113 (1973) and its progeny, and
particularly on the expansive language in Planned Parenthood v. Casey, 505 U.S. 833,
851 (1992), which, read in the abstract, seems to uphold the right of terminally ill people
(and a great many others) to enlist the assistance of a physician in committing suicide.
The Casey Court stated: "the right to define one's own concept of existence" is at "the
heart of liberty", and the right to make "the most intimate and personal choices" is "cen-
tral to the liberty protected by the Fourteenth Amendment." Casey, 505 U.S. at 851. But
see text infra at notes 128-36.

A year before the Ninth Circuit handed down its en banc ruling in Compassion in
Dying, this author tried to distinguish the abortion cases and contain the sweeping lan-
guage in Casey. See Yale Kamisar, Against Assisted Suicide—Even A Very Limited Form,
efforts to reconcile support for the abortion cases with opposition to a claimed right to
physician-assisted suicide, see Seth F. Kreimer, Does Pro-Choice Mean Pro-Kevorkian?
An Essay on Roe and Casey and the Right to Die, 44 Am. U. L. Rev. 803 (1995); Marc
Spindelman, Are the Similarities between a Woman's Right to Choose an Abortion and the
See also Thomas J. Marzen, "Out, Out Brief Candle": Constitutionally Prescribed Suicide
for the Terminally Ill, 21 Hastings Const. L. Q. 799, 805, 822-23 (1994); Franklin G.
Miller, Legalizing Physician-Assisted Suicide by Judicial Decision: A Critical Appraisal,


11. See id. at 279. Moreover, Justice O'Connor, who cast the pivotal vote and wrote
an important concurring opinion, talked repeatedly about the "restraint and intrusion"
necessarily involved in the imposition of medical treatment on "an unwilling competent
adult" and how a patient "whose wishes are not honored may feel a captive of the machin-
ery required for life-sustaining measures or other medical interventions." See id. at 288-
89.

Two years later, in Planned Parenthood v. Casey, 505 U.S. 833, 857 (1992), the
Court observed that Roe v. Wade "may be seen...as a rule...of personal autonomy and
bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power
to mandate medical treatment or bar its rejection." Casey, 505 U.S. at 857. The Court
then cited the Cruzan case as in "accord with Roe's view that a State's interest in the
protection of life falls far short of justifying any plenary override of individual liberty
claims." Id. As Seth Kreimer has observed, "[e]xactly what 'non-plenary' overrides are
acceptable is left ambiguous." See Kreimer, supra note 9, at 833 n.102.
Moreover, after observing that a state has an undeniable interest in "the protection and preservation of human life," at one point in Chief Justice Rehnquist's opinion for the Court in *Cruzan*, he supported this assertion by noting that "the majority of states in this country have laws imposing criminal penalties on one who assists another to commit suicide." If the Court was suggesting that anti-assisted suicide laws were constitutionally suspect, it chose a strange way of doing so.

Although the press and public have often labelled both *Cruzan* and the landmark *Quinlan* case "right to die" cases, the only right or liberty at issue in those cases was the right to be removed from artificial life support systems or, as many have called it, the right to die a natural death. When the *Compassion in Dying* majority informed us that "there is, in short, a constitutionally recognized 'right to die,'" however, the court contemplated a much broader right.

As Alexander Morgan Capron has noted, the Ninth Circuit viewed the right to forgo unwanted medical treatment and the right to enlist the assistance of a physician in dying by suicide (and the right to authorize a physician to administer euthanasia?) as merely subcategories of the same broad right or liberty interest, "controlling the time and manner of one's death" or "hastening one's death." The Ninth Circuit did not merely ignore the distinction between terminating life support or "letting die" and actively intervening to promote or to bring about death; rather, it disparaged the distinction:

[W]e do not believe that the state's interest in preventing [physician-assisted suicide] is significantly greater than its interest in preventing the other forms of life-ending medical conduct that doctors now engage in regularly. . . . [W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other. . . .

16. *Compassion in Dying*, 79 F.3d at 816. (Emphasis added.)
18. See *Compassion in Dying*, 79 F.3d at 802.
Moreover, we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as “suicide.” Certainly, we see little basis for such a classification when deaths that result from patients’ decision to terminate life support systems or to refuse life-sustaining food and water, for example, are not. . . .

If the Compassion in Dying majority belittled the distinction between “letting die” and actively intervening to promote or to bring about death, it did not treat more kindly the distinction between assisting in a suicide and administering pain killers that hasten a patient’s death. If anything, the court dismissed this distinction even more peremptorily; stating:

Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a “double effect” — reduce the patient’s pain and hasten his death. . . . [under the circumstances, there] can be no doubt [that] the actual cause of the patient’s death is the drug administered by the physician or by a person acting under his suspicion or direction. . . .

[We] see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient’s life.20

John Arras described the Compassion in Dying majority’s position both crisply and accurately when he summarized it as follows:

[T]here is no significant difference between withdrawing a ventilator, discontinuing a feeding tube, administering pain-killing but (potentially) life-shortening opioids, and prescribing a lethal dose of barbiturates. In all these cases, the judges allege, the intention is the same (to hasten death), the cause of death is the same (an act attributable to human agency), and the social risks of mistake and abuse are the same (misdiagnosis, undue pressure, and so forth).21

Although the Quill court summarily rejected the Compassion majority’s “substantive due process” analysis,22 it was no more impressed than the other court had been with the “action-inaction distinction” or, more specifically, the difference between “allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing

19. Id. at 824. But see text infra at notes 40-66.
20. Id. at 823-24. But see text infra at notes 72-92.
21. John Arras, News from the Circuit Courts: How Not to Think About Physician-Assisted Suicide, 2 BroLaw S:171, S:180 (Special Section, July-Aug. 1996). Actually, Professor Arras is summarizing what he believes to be the position of both the Compassion in Dying court and the Quill court. It is not clear, however, how the Quill court views administering pain-killing opioids. But the Second Circuit does make one passing remark about the administration of palliative drugs that suggests its position may be the same as the Ninth Circuit’s. See text infra at note 27.
22. See supra note 5.
device.” Indeed, the Quill court went a step further. What the court considered to be “the moral and legal identity of those two modes of hastening death [became] the crux of [its] argument for prohibiting laws banning assisted suicide.”

The Quill court reminded us that the Equal Protection Clause, “directs that 'all persons similarly circumstanced shall be treated alike,'” but New York had not done so: terminally ill persons on life support systems “are allowed to hasten their death by directing the removal of such systems,” but persons off life support who are “similarly situated” except for being attached to lifesaving equipment “are not allowed to hasten death by self-administering prescribed drugs.” The Quill court would have society believe that much like the person who had been speaking prose throughout his or her life without knowing it, many physicians and other health professionals have been helping people commit suicide almost everyday of their professional lives without realizing it:

Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

23. Quill, 80 F.3d at 729 (quoting the district court, which had found such a distinction significant).
24. See Miller, supra note 9 at S:139.
25. Quill, 80 F.3d at 725.
26. Id. at 729. “A finding of unequal treatment,” added the court, “does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest.” Id. The court next concluded that to the extent that the statute prohibited a physician from assisting a mentally competent, terminally-ill person to die by suicide, it was “not rationally related to any legitimate state interest.” Id. at 731.
27. Id. at 729 (emphasis added). Actually, if one shares the Quill court’s view that the action-inaction distinction is irrelevant and takes the Quill court’s argument where it logically leads, ending a person’s life by removing the person’s life support would be more than assisted suicide; it would be voluntary euthanasia. Assisted suicide occurs when another person renders assistance (for example, provides the lethal drugs), but the suicidal individual personally commits the last act, that is, the one that brings about death. That is not an accurate description, however, of what happens when a physician terminates life support. In such a case, according to the Quill court, it is the physician who is performing the last, death-causing act, and this constitutes euthanasia, not assisted suicide. See Yale Kamisar, Physician-Assisted Suicide: the Last Bridge to Active Voluntary Euthanasia, Euthanasia Examined 225, 228-29, 230-33 (John Keown ed., 1995). As those individuals who have read this author’s previous writings on the subject know, this author believes there is a significant distinction between the termination of life support and active intervention to promote or to bring about death. Assuming arguendo, however, that the distinction is neither legally or morally significant (the view of both the Compassion and Quill courts), the “active” counterpart to forgoing life-sustaining treat-
As Justice William Brennan pointed out in his *Cruzan* dissenting opinion, more than three-fourths of the two million people who die in this country every year do so in hospitals and long-term care institutions and most of these individuals die "after a decision to forgo life-sustaining treatment has been made."28 "Under the [Quill] court's logic," observes George Annas, "there is an epidemic of suicide and homicide in the nation's hospitals."29

With all deference, this author finds it hard to believe that the *Quill* court thought through where its rationale would lead and whether it was prepared to go there.30 What the *Quill* Court did, in effect, was to lubricate the "slippery slope" with the Equal Protection Clause.

As this author understands and applies the *Quill* analysis, the analysis leads to the following conclusions: (a) mentally competent, non-terminally ill people who are not attached to life-sustaining equipment have a right to determine the time and manner of their deaths because *if they were on life support*, they would be able to do so by directing the removal of such support;31 (b) mentally competent, terminally ill people (and if this author is right about part (a), non-terminally ill people as well) who are unable to perform the last, death-causing act themselves and thus need a physician to perform the act for them (e.g., administer a lethal injection), are entitled to physician-administered voluntary euthanasia because, except for the arbitrary fact that they lack the capacity to perform the death-producing act themselves, these people are "similarly situated" to other mentally competent persons who wish to "hasten their deaths" and are able to perform the "last act" themselves.32

Although one gains no inkling of these conclusions from the *Quill* opinion, the right to forgo life-saving medical treatment is not limited to the terminally ill or, if the state's standard of proof is satisfied, to those individuals in a persistent vegetative state. Stated more forcefully by a leading expert on the subject: "The

---

28. See *Cruzan*, 497 U.S. at 302-03.
29. George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQUESNE L. REV. 875, 896 (1996). "Homicide" is an ugly word, but if one takes the *Quill* court's analysis seriously, an "epidemic" of "homicide" is not mere hyperbole. For the reasons discussed in note 27 supra, *Quill*'s logic does lead to the conclusion that what has been going on in the nation's hospitals for many years is technically "homicide," not "suicide" or "assisted suicide." See supra note 27.
30. See text supra at note 1.
31. See text infra at notes 138-39.
32. See discussion in text infra following note 36 and note 162.
right of a competent person to refuse medical treatment is virtually absolute.” If, as the Quill court indicates, there is no legally cognizable distinction between competent, terminally ill persons off life-support who wish to “hasten their deaths” but cannot do so, and “similarly situated persons who are on life support and thus able to control the time and manner of their deaths, then the same reasoning leads to the conclusion that competent, non-terminally ill persons who are off life support and unable to control the timing of their deaths are being treated “unequally.”

The Quill court’s Equal Protection analysis also bears on the viability of the distinction between physician-assisted suicide where the suicidal individual performs the last, death-causing act, and physician-administered active voluntary euthanasia where the physician does not merely provide assistance to the suicidal individual but also performs the act that actually brings about the individual’s death. Unlike the Compassion in Dying majority, whose position on this issue appears rather tentative, the Quill court seems quite willing to honor the distinction between assisted suicide and active voluntary euthanasia. It is


Probably the best known case involving a non-terminally ill person’s right to terminate life-sustaining medical treatment is Bouvia v. Superior Court (Glencurh), 225 Cal. Rptr. 297 (1986). The trial court had denied Ms. Bouvia’s request to have her feeding tube removed because, with sufficient feeding, she could live an additional fifteen or twenty years. Thus, as the appellate court described the trial court’s position, “the preservation of petitioner’s life for that [15-20 year] period outweighed her right to decide.” The Court of Appeal disagreed, stating:

In Elizabeth Bouvia’s view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. . . . If her right to choose may not be exercised because there remains to her, in the opinion of a court, a physician or some committee, a certain arbitrary number of years, months, or days, her right will have lost its value and meaning.

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but the decision must ultimately belong to the one whose life is in issue.

Bouvia, 225 Cal. Rptr. at 304-05.

34. See supra note 27.
35. See text infra at note 144.
36. In response to the argument that the state had an interest in “preventing the sort of abuse that has occurred in the Netherlands,” the Quill court pointed out that the relief sought by the plaintiffs would not lead to such abuse because they “do not argue for euthanasia at all,” only for assisted suicide for terminally ill patients “who would self-
highly unlikely, however, that this distinction could survive the kind of equal protection analysis that the Second Circuit utilized in Quill.

If the only reason a person cannot avail himself or herself of physician-assisted suicide is because the person is unable to perform the last, death-causing act alone, this situation seems no less arbitrary and no more relevant than the fact that a person does not happen to be dependent on a life-support system. If a person otherwise "eligible" for physician-assisted suicide and otherwise determined to end his or her life by the active intervention of another needs someone else to administer the lethal medicine, how can the person be denied this right or liberty (assuming it is a right or liberty) simply because the person cannot perform the last, death-causing act alone?

Consider the following easy case: Suppose the right of mentally competent, terminally ill persons to commit suicide with the assistance of a physician has been established. Suppose, further, that a competent terminally ill person seeking the active intervention of a physician to end his or her life is unable to perform the last, death-causing act personally. Would not denying such person the particular relief sought and needed (the administration of a lethal injection) constitute, to use the language of the Quill court, a failure to "treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths?"

Professor Henkin observed that "Judgment consists in drawing lines, not in staying put, nor in following blindly where the inertia of motion leads." Henkin also noted, however, that "a doctrinal line must have a reason: that a line has to be drawn somewhere does not mean that it may be drawn anywhere."

In this article, the author contends that the Compassion in Dying and Quill courts adhered to some lines that cannot be defended on principle. This author also argues that, on the other hand, the Compassion in Dying and Quill courts belittled and then erased some lines that should have been maintained.

As for drawing lines where they should not be drawn, this author submits that if a court believes respect for "self-determination" and "personal autonomy" entitles a competent person to decide whether, when and how he or she chooses to end her life, that "right" or "liberty" should not be (and will not be) limited to administer the drugs." See Quill, 80 F.3d at 730-31. Moreover, the court noted that "euthanasia falls within the definition of murder." Id. at 730 n.3.

37. Id. at 727.
38. Henkin, supra note 1, at 63.
39. Id.
the "terminally ill." This author also submits that (even putting aside the Quill court's Equal Protection analysis) the thin and shaky distinctions between assisted suicide and active voluntary euthanasia, distinctions so fine that sometimes reasonable people cannot agree in which category a physician's conduct falls, cannot be defended on principle or maintained in practice.

Judgment consists in knowing what lines to erase as well as which lines to draw and where to draw them. Not only is this author convinced that two of the boundaries that the Compassion in Dying and Quill courts respected are misplaced and will not long endure, this author believes that the courts wiped out distinctions that should be preserved.

Initially, it is important to maintain the line between forgoing life-sustaining medical treatment and actively intervening to promote or to bring about death, which is a line that both the Compassion in Dying and Quill courts erased (or would have people believe society has already effectively erased). Despite the Compassion in Dying majority's belittling of the "double-effect" principle and its erasure of the line between euthanasia and the administering of pain relief that may unintentionally but foreseeably hasten death (or the court's assumption that this distinction has already been eliminated in practice), the difference between providing risky pain relief and engaging in active euthanasia is much more significant than the judges of the Ninth Circuit (and others) believe or have assumed.

I. TERMINATION OF LIFE SUPPORT V. SUICIDE, ASSISTED SUICIDE, AND HOMICIDE

As several commentators have pointed out, the Compassion in Dying and Quill cases shattered a general consensus that withholding or withdrawing life-saving treatment constitutes neither suicide nor assisted suicide nor homicide.40 Starting with Quinlan, various state supreme courts had explicitly recognized the significance of the distinction between refusals of medical treatment and active intervention to end life.41 To be sure, "the moral significance of the distinction has been subjected to periodic philosophical challenge," but the distinction "has remained a basic tenet of health care law and mainstream medical ethics."42

Some of the reasons commonly advanced to distinguish death caused by the removal of life support systems from death caused

40. See Annas, supra note 29, at 897; Arras, supra note 21, at S:171; Miller, supra note 9, at S:141.
41. See Annas, supra note 29, at 897.
42. Miller, supra note 9, at S:141.
by the suicide of people not dependent on life support are, to borrow a phrase, "not altogether persuasive."\footnote{43} (For example, unpersuasive reasons are those such as the death results from the removal of life support, the "cause" is not the act of removal but the patient's underlying illness; or the patient lacked "a specific intent to die"; or the physician only "intended" to free the patient of unwanted technology.)\footnote{44} The fact that some arguments made on behalf of the distinction between declining medical treatment and active intervention to bring about death are not convincing, however, does not mean that the distinction cannot be defended on other grounds. Indeed, two commentators who have expressed dissatisfaction with the explanations or justifications often given have gone on to defend the distinction on other grounds.\footnote{45}

Until the recent \textit{Compassion in Dying} and \textit{Quill} rulings, the so-called "right to die" meant only a "right against intrusion,"\footnote{46} a right to resist "a direct invasion of bodily integrity, and in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity."\footnote{47} To be sure, a total prohibition against assisted suicide does close an "avenue of escape," but, unlike a refusal to honor a competent patient's request to terminate life-sustaining treatment, it does not force one into "a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals."\footnote{48} The view that forced medical treatment represents "a violation of personal autonomy and physical integrity totally incompatible with the deepest meaning of our traditional respect for liberty"\footnote{49}

\footnote{44. For criticism of these arguments, see, \textit{e.g.}, Arras, \textit{supra} note 21, at S:181; Miller, \textit{supra} note 9, at S:141-S:142; Rubenfeld, \textit{supra} note 43.}
\footnote{45. The two commentators are bioethicist John Arras and law professor Jed Rubenfeld, both of whom are quoted at length in this section of the article. For their criticism of the reasons commonly advanced for the distinction, see material cited \textit{supra} in note 44.}
\footnote{46. \textit{NEW YORK STATE TASK FORCE REPORT}, \textit{supra} note 33, at 71. See also Miller, \textit{supra} note 9, at S:146-147.}
\footnote{47. \textit{NEW YORK STATE TASK FORCE REPORT}, \textit{supra} note 33, at 71.}
\footnote{48. Rubenfeld, \textit{supra} note 43, at 794.}
\footnote{49. Arras, \textit{supra} note 21, at S:182.}
is reflected in Justice O'Connor's pivotal concurring opinion in *Cruzan*:

A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion...

...Feeding a patient by means of a nasogastric tube requires a physician to pass a long flexible tube through the patient's nose, throat, and esophagus and into the stomach. Because of the discomfort such a tube causes, "[m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube...Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment."

The different consequences of a failure to comply with a request to terminate treatment and a failure to honor a request for assisted suicide indicate that these two means of bringing about death are not, and should not, be considered the same:

When doctors fail to honor a competent patient's informed refusal of treatment the patient becomes subjected to unwanted bodily intrusion. If on life support, the patient forced to endure unwanted treatment becomes a prisoner of medical technology. Out of respect for patient autonomy, doctors are duty-bound to honor informed refusals of life-sustaining treatment by competent patients. A terminally ill patient who requests assisted suicide, by contrast, is asking for a "treatment" that lies outside standard medical practice...To deny such a request because, for example, the doctor believes that standard palliative care could relieve the patient's suffering certainly restricts patient self-determination, but it does not amount to a bodily invasion or medical imprisonment.

...Unlike a competent refusal of treatment, a competent request for physician-assisted suicide does not [or, at least, did not until March of this year] amount to a moral and legal trump that can compel a doctor's compliance.

---

50. *Cruzan*, 497 U.S. at 288-89. As this author has discussed elsewhere, it may be useful to view the *Cruzan* case as involving two competing traditions: the right to refuse medical treatment and the anti-suicide tradition (as evidenced by society's discouragement of suicide and by the many criminal laws against assisted suicide). See Kamisar, *supra* note 15, at 35. In *Cruzan*, a majority of the Court, perhaps as many as eight justices, evidently decided that the termination of artificial nutrition and hydration was more consistent with the rationale of the cases upholding the right to reject treatment. No person can know for sure what the other justices thought, but only Justice Scalia, who wrote a lone concurring opinion, expressed the view that the case implicated the anti-suicide tradition. *Cruzan*, 497 U.S. at 292.

51. Miller, *supra* note 9, at S:142. One might add that if a physician does deny a request for suicide because the physician believes appropriate pain relief is available and such relief is then provided, "many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment." *New York State Task Force Report*, *supra* note 33, at xiv.
Not only would a prohibition against rejecting life-sustaining treatment impose a more onerous burden on persons affected than does a ban against assisted suicide (indeed, in some cases a ban against forgoing or terminating life support could lead to the almost total "occupation" of a person's life by medical machinery and the "expropriation" of a person's body from his or her own will), it would also impair the autonomy of a great many more people.

As noted earlier, most of the two million people who die every year do so after refusing some form of medical intervention. If life-sustaining treatment could not be rejected, vast numbers of patients would be "at the mercy of every technological advance." Moreover, if patients could refuse potentially lifesaving treatment at the outset but not discontinue the treatment once it went into effect, many patients probably would not seek such treatment in the first place.

In short, allowing a patient to die at some point is a practical condition upon the successful operation of medicine. The same can hardly be said of physician-assisted suicide or physician-administered active voluntary euthanasia. Moreover, "the practice of forgoing treatment is by now so deeply embedded in our social and medical practices that a reversal of policy on this point would throw most of our major medical institutions into a state approaching chaos." Again, the same can hardly be said of a refusal to comply with requests for physician-assisted suicide or physician-administered active voluntary euthanasia.

The Compassion in Dying majority assumed that the process of administering physician-assisted suicide "can be carefully regulated and rigorously safeguarded," and probably contemplated such procedures to be like those required by a recently proposed "Model State Act."
Unlike the fairly elaborate procedures that most assume will condition the administration of physician-assisted suicide, for example, waiting periods, mandatory discussions, witnesses and documentation,\textsuperscript{59} there are currently very few restrictions on the right to forgo life-sustaining medical treatment. Approximately all that is needed is for the patient to have decision-making capacity and understand the medical options available and the consequences of those options.\textsuperscript{60} If there is "no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and prescribing drugs which will permit a terminally ill patient to end his [or her] own life,"\textsuperscript{61} however, why should any more restrictions be imposed on one means of bringing about death than the other?\textsuperscript{62}

Whether a regulatory mechanism provides patients and physicians with much-needed protection or unduly burdens the underlying right is largely in the eye of the beholder. Although the drafters of the Model Act are convinced that a statute authorizing physician-assisted suicide must contain strong safeguards, they recognize that at a time which is likely to be extremely difficult for both patients and families, the patients and family members will "often quite reasonably view the procedures as a profound invasion of their privacy."\textsuperscript{63}

If those persons who are unhappy with the many procedural safeguards likely to be contained in laws authorizing physician-assisted suicide wish to challenge such laws, they need only fall back on the Quill case's Equal Protection analysis. If, as Quill acknowledged, all "similarly situated" persons must be treated alike, and if, as Quill concluded, persons who desire to die by physician-assisted suicide are "similarly situated" to those on life-support who also wish to die, why should the persons seeking to "hasten their death" by one route have to put up with any more restrictions than those seeking to "hasten their death" by another route? Why isn't this a denial of equal protection?

There is, of course, another possibility. The legalization of physician-assisted suicide and the view that both physician-
assisted suicide and the rejection of life-sustaining treatment are only subcategories of the same general right to control the time and manner of one's death may "work backwards," and may lead to the imposition of new mandatory safeguards (a.k.a. restrictions) on "the hard-won rights that the great majority of patients can and do now exercise to refuse medical treatments," restrictions that may "actually frustrate rather than foster the self-determination of patients"\textsuperscript{64}

Susan Wolf, a professor of both law and medicine at the University of Minnesota, anticipated such a development seven and a half years ago. Wolf argued that the prohibition against active euthanasia (and as Wolf would probably agree, physician-assisted suicide as well) has been an essential backdrop for obtaining reasonably good court decisions and developing reasonably good medical practices governing termination of life support and end-of-life care. Specifically, Wolf stated:

[The prohibition against active euthanasia] has served as a dam...Remove that dam and a flood will surely overwhelm us. The courts and the prosecutors will rush in...

[The prohibition against euthanasia and, this author would add, physician-assisted suicide as well] has to a large extent allowed the law to stay out of the way. Judges generally have encouraged those involved in termination of treatment decisions to steer clear of the courts; legal authorities have almost always determined these bedside treatment decisions are not the province of the criminal law; and the states for the most part have avoided requiring a great deal of formality and paperwork. Thus, there has been an overall toleration of relatively informal, nonlegalistic processes and a trust in the commitment of physicians to do no harm.

Second, maintenance of the prohibition has allowed a properly expansive reading by the courts of the right to refuse life-sustaining treatment. The courts have recognized this right for nonterminal patients, including those whose treatment is relatively simple and unburdensome. Dealing with active euthanasia, the courts might have been far more reluctant to reach the nonterminal, less burdened patient. Even the right of incompetents might have been threatened.\textsuperscript{65}

Whether the right to forgo life-saving treatment will become more restricted or whether the many conditions and requirements that people assume will accompany physician-assisted suicide will turn out to be less rigorous than expected remains to be seen. In the meantime, this author shares Professor Miller's view that if the Quill court's Equal Protection analysis "is applied consistently, either the right of patients to forgo treat-

\textsuperscript{64} Annas, \textit{supra} note 33, at 686.

\textsuperscript{65} Wolf, \textit{supra} note 33, at 13.
ment will become more burdened by restrictions, thus diminishing patient autonomy, or assisted suicide will become available as an unfettered right of competent, terminally ill people.\footnote{66}

II. ACTIVE EUThANASIA v. THE USE OF ANALGESICS THAT HASTEN DEATH

At one point, the \textit{Compassion in Dying} majority observed:

As part of the tradition of administering comfort care, doctors have been supplying the causal agent of patients' deaths for decades. Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a “double effect” — reduce the patient’s pain and hasten his death. Such medical treatment is accepted by the medical profession as meeting its highest ethical standards. It commonly takes the form of putting a patient on an intravenous morphine drip, with full knowledge that, while such treatment will alleviate his pain, it will also indubitably hasten his death. There can be no doubt therefore, that the actual cause of the patient's death is the drug administered by the physician or by a person acting under his supervision or direction.

...[W]e see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient’s life.\footnote{67}

The fact that a court that arrived at the conclusions that the \textit{Compassion in Dying} majority would conflate assisted suicide (or active euthanasia) with the administering of painkillers that hasten a patient’s death is hardly surprising, for “[p]roponents of active euthanasia [or assisted suicide] condemn the supposed hypocrisy of law in allowing analgesics that hasten death while prescribing euthanasia,” and maintain that “killing in order to relieve suffering has already been legally authorized in the context of risky pain relief.”\footnote{68}

Two years ago, for example, Dr. Thomas Preston, a proponent of physician-assisted suicide,\footnote{69} asserted that “the morphine drip

\footnote{66. Miller, supra note 9, at S:143.} \footnote{67. \textit{Compassion in Dying}, 79 F.3d at 823-24.} \footnote{68. Norman L. Cantor & George C. Thomas, \textit{Pain Relief, Acceleration of Death, and Criminal Law}, 6 KENNEDY INST. OF ETHICS J. 107, 109 (June 1996).} \footnote{69. Dr. Preston was identified only as a cardiologist and a professor of medicine at the University of Washington. However, as pointed out in Richard Doerflinger, \textit{Letter to the Editor}, N.Y. TIMES, Nov. 7, 1994, p. A14, Preston had played a major role in the unsuccessful 1991 campaign to legalize “aid-in-dying” in Washington State. “Aid-in-dying” is a label covering both assisted suicide and voluntary euthanasia. Doerflinger might have added that Dr. Preston was a medical advisor to Compassion in Dying (an organization that provides professionals who help terminally ill people commit suicide), as well as one of the plaintiffs in \textit{Compassion in Dying}, a lawsuit to invalidate Washington's anti-assisted suicide law that had commenced some months before Preston wrote his Op-ed column.}
is undeniably euthanasia, hidden by the cosmetics of professional tradition and language. From this premise, Dr. Preston argued that physicians should be permitted to do "openly and honestly" what they already do "secretly and silently." Dr. Preston's provocative assertions evoked criticism on both ethical and empirical grounds.

For example, Dr. Kenneth Prager, a medical ethicist, retorted that while "[o]ne of the goals of both physician and lay advocates of euthanasia" is to "desensitize society to euthanasia" by "blur[ring] the distinction between mercy killing and the merciful use of drugs that may unintentionally hasten death," such a distinction "is crucial to the integrity of the medical profession and to the sanctity in which our society holds life." Thomas Quinn, who was an oncology clinical nurse specialist with over a dozen years experience with morphine drips in hundreds of cases maintained that "most of these patients were quite alert" and "many were able to be independent in caring for themselves." Furthermore, although most of the patients had advanced stages of cancer, "very few" were interested in an early death; "even less so were their families, nurses or physicians." Moreover, the many physicians with whom Thomas Quinn had experience "have been more likely to underdose than to overdose, precisely because of the usually unfounded fear of respiratory depression."

Like Dr. Preston's earlier effort, the Ninth Circuit's attempt to conflate the use of opioids to relieve pain with assisted suicide or euthanasia drew heavy fire. Criticism with respect to this attempt did not appear in a "letters to the editor" column, however, but in professional journals.

70. Thomas A. Preston, Killing Pain, Ending Life, N.Y. TIMES, Nov. 1, 1994, at A15. Dr. Preston described the morphine drip as "a slow, continuous injection of the pain-killer into a vein" that kills the patient "by gradually curtailing her breathing." Id.

71. Id.

72. Kenneth Prager, Letter to the Editor, N.Y. TIMES, Nov. 7, 1994, at A14. At the time Dr. Prager wrote this letter, he was Chairman of the Medical Ethics Committee of the Columbia Presbyterian Medical Center.

73. Thomas E. Quinn, Letter to the Editor, N.Y. TIMES, Nov. 7, 1994, at A14. At the time Thomas Quinn wrote the letter, he was an oncology clinical nurse specialist at the Lombardi Cancer Research Center, Washington, D.C.

74. Id.

Bioethicist Howard Brody's criticism to the Ninth Circuit's above mentioned attempt must be regarded as the most noteworthy both because of the force of Brody's attack on the Ninth Circuit's argument and because he is a proponent of physician-assisted suicide (in exceptional cases and subject to stringent safeguards). After stating that "even those who might support the legalization of physician-assisted suicide should take little comfort in [the Ninth Circuit's] ruling," Dr. Brody proceeded to explain why. As to the empirical component of the Compassion in Dying majority's assertion, Brody stated:

Caregivers experienced in hospice settings know that it is extremely difficult to produce a fatal overdose by increasing the amount of opioid administered to a patient suffering pain. This is especially true when the agent is titrated with care and when the patient has been receiving an opioid long enough to build up tolerance. Indeed purveyors of "how to" advice on suicide assistance warn patients against relying upon opioids as agents for a deliberate suicide attempt. . . .

If the myth of widespread respiratory depression and early death persists, then physicians will conclude two things. First, they will view adequate pain relief in terminal care as tantamount to killing the patient. Some will seek ethical justification for this course of action, but others will simply avoid giving enough medicine and will leave their patients suffering. Second, physicians will conclude that the moral difference between physician-assisted suicide and adequate pain control while dying is merely a semantic quibble. Both conclusions are deleterious to the humane care of the dying patient.

As to the ethical component of the Compassion majority's assertion, Brody stated:

By treating [the "principle of double effect"] as mere logic-chopping, the court illustrates its own poor grasp of professional ethics. The principle of double effect applies to situations where the foreseeable consequences of one's action differ from one's intentions. In the case of terminal pain, the physician (presumably) intends to relieve pain but not necessarily to shorten the patient's life. Giving opioids runs a certain risk of shortening life; but it is also the only effective way to relieve pain. (If a new opioid were invented tomorrow that reduced pain with equal effectiveness but without posing any risk of respiratory depression, hospice physicians would unhesitatingly switch to that drug.) The moral question is whether the good intentions, and the good result of pain relief, are adequate to justify running the risk of the unintended consequence, an earlier death. Time-

76. See Miller et. al., supra note 58, at 119. See also Howard Brody, Assisted Death—A Compassionate Response to a Medical Failure, 327 NEW. ENG. J. MED. 1384, Nov. 5, 1992; Franklin G. Miller & Howard Brody, Professional Integrity and Physician-Assisted Death, HASTINGS CENTER REP., May-June, 1995, at 8.
77. Brody, supra note 75, at S:154.
78. Id. at S:156.
honored ethical analysis has answered this question in the affirmative.

Even many who have argued that accepting treatment refusal entails accepting assisted death are still content to leave double effect deaths in a separate moral category. The practical implication of this ethical analysis for today's practice lies with the substantial minority of physicians who are steadfastly opposed to assisted suicide and who would refuse to participate in such actions even if they were legalized. So long as the principle of double effect applies, these physicians may be exhorted to provide fully adequate pain relief for all terminal patients without fearing that they are compromising their moral integrity. But if the court is allowed to make the case that double effect deaths are morally no different from assisting a patient's suicide, than a large number of practitioners—perhaps one-third—would have strong moral grounds for refusing to treat terminal pain with adequate doses of opioids. The impact on medicine's already-suboptimal level of compassionate care of terminal suffering could be disastrous.79

It is unclear from Brody's article whether his position is that whenever a physician administers analgesics to relieve suffering the physician's good intentions always justifies running the risk of the patient's earlier death, that is to say, providing risky pain relief is justifiable regardless of how certain or probable the risk of death may be. This position does, however, seem to be the Compassion in Dying majority's view of how the "double-effect" principle works.80 Moreover, the "common wisdom" is that, however great the risk of accelerating death, the administration of analgesics is lawful as long as the physician's primary intent is to relieve pain rather than to cause death.81

Recently, Norman Cantor, an expert in the law and ethics of death and dying, and George Thomas, an expert in criminal law, examined this common wisdom and found it too simplistic.82 In the process, Cantor and Thomas managed to fortify the distinction between administering pain relief that may hasten death

79. Id. at S:157. Arras has noted the following:
In view of the manifest resistance of most physicians to participate in acts of assisted suicide or direct killing, [the Ninth and Second Circuit's] attempt to conflate the provision of adequate pain control with assisted suicide or euthanasia constitutes, in my opinion, a reckless, ill-informed, and counterproductive gesture; ill-informed because both [courts] seem to assume that adequate doses of such opioids will invariably shorten life, whereas the truth is that the expert administration of such drugs will not usually have this effect; reckless and counterproductive because many physicians would sooner give up their allegiance to adequate pain control than opposition to assisted suicide and euthanasia. If they are convinced by the judge's reasoning, many will be reluctant to practice adequate pain control techniques on their dying patients.

Arras, supra n. 75 at S:187 n.23.

80. See text supra at note 67.
81. See authorities cited in Cantor & Thomas, supra note 68, at 108.
82. See id. at 108-11.
and engaging in active voluntary euthanasia. Cantor and Thomas argue, quite persuasively, that regardless of what moral philosophers may say about the physician’s culpability when the use of analgesics designed to ease pain causes prompt death, as a matter of criminal law the physician’s motive or desire to relieve pain does not automatically or necessarily justify the physician’s conduct.83 Clearly, running some risk of death in order to obtain relief from pain is legally justifiable, but “the risk must be at least roughly commensurate with the gain.”84

For example, if the situation were such that no analgesic dosage could provide pain relief without also causing prompt death (or if under the circumstances there was a 99% chance that any analgesic dosage would cause death), the physician who administered analgesics would be criminally liable for the resulting death even though death was not intended as a result.85 Indeed, these deaths would be “knowing” homicides as “knowing” is defined in the Model Penal Code.86

As Cantor and Thomas note, “[t]he uniform judicial position in the United States that euthanasia is always unjustified homicide reflects a view that pain relief can never outweigh the harm” of purposely (acting with the “conscious object” of bringing about the result) or knowingly (acting with awareness that one’s conduct is “practically certain” to bring about a particular result)

83. See id. at 110-11, 119, 122-23. This author deliberately avoids use of the term “purpose,” because it has generated so much confusion in the past. See Yale Kamisar, Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia, EUTHANASIA EXAMINED 225, 257-58 n. 116 (John Keown ed. 1995). One example of such confusion is that when Dr. Jack Kevorkian was acquitted of assisting in the suicide of Thomas Hyde, some jurors seemed genuinely confused about the distinction between Kevorkian’s motive, what might be called his “ulterior purpose” (to relieve Hyde of his pain and suffering), and Kevorkian’s intent, what might be called his “immediate purpose” (to bring about Hyde’s death).

Although the trial judge in the aforementioned Kevorkian prosecution failed to distinguish between “motive” and “intent,” the need to do so was heightened by the Michigan anti-assisted suicide law then in effect. The prohibition against assisted suicide adopted a version of the “double effect” principle; it contained an exception for “prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and not to cause death, even if the medication or procedure may hasten or increase the risk of death.” (Emphasis added.) See id. at 258 n.116. Although Kevorkian claimed that he came within this exception and the trial judge treated his claim equivocally, I think it clear that the exception did not apply to Kevorkian’s conduct. The exception applies when death is a byproduct (albeit a foreseeable byproduct) of attempts to relieve pain and suffering by administering or increasing a dose of narcotics; it does not apply when death is the result intended. When Kevorkian supplies a patient carbon monoxide, or some other lethal agent, whatever his “motive,” his intent is to cause death.

84. Cantor & Thomas, supra note 68, at 119.
85. See id.
86. See text at note 87 infra and accompanying footnote.
causing a premature death.\textsuperscript{87} Of course, it will often be extremely difficult to prove that the physician acted "purposely" or "knowingly," and even when this can be established many prosecutors may decline to prosecute.)\textsuperscript{88}

Moreover, if it were highly likely that the administration of an analgesic would cause prompt death (for example, a 75-90% chance), the physician who used the painkillers that caused the death would still be criminally liable.\textsuperscript{89} Although in the hypothetical case the physician did not desire or intend to bring about death, death was so highly foreseeable that the physician acted "recklessly" within the meaning of the Model Penal Code.\textsuperscript{90} As Cantor and Thomas suggested when discussing this hypothetical (and this author thinks they are right), although moral philosophers may differ, as a matter of criminal law theory the strong probability that death will result "is not warranted by the small chance of providing pain relief without death."\textsuperscript{91}

In sum, Cantor's and Thomas's analysis of the criminal law framework as applied to assisted suicide demonstrates that the difference between the administration of risky pain relief and the administration of active voluntary euthanasia is more significant than many people believe or have assumed, and that, although there is admittedly "a tension between the legality of risky pain relief and the illegality of euthanasia," "the legal distinction is logically tenable."\textsuperscript{92}

\textsuperscript{87} See Cantor & Thomas, at 111, 119. As Cantor & Thomas point out, in terms of homicide culpability, Sections 2.02 (2) and 210.2 of American Law Institute, Model Penal Code (official Draft, 1962) do not draw a distinction between "purposeful" and "knowing" acts. Id. at 124 n.7.

As one of the nation's leading criminal law scholars has observed, the Model Penal Code, the product of many years of research, deliberation, drafting and revising, is "the point of departure for criminal law scholarship and the greatest single influence on the many new state codes that have followed in its wake." Sanford Kadish, The Model Penal Code's Historical Antecedents, 19 Rutgers L.J. 521 (1988).

\textsuperscript{88} Moreover, the legislature may enact a statute providing that the intent of a physician to relieve pain and suffering does automatically justify the administration of analgesics, no matter how probable or certain it is that such a procedure will bring about a prompt death. Michigan's temporary prohibition against assisted suicide, discussed in note 83 supra, seems to carve out such an exception.

\textsuperscript{89} See Cantor & Thomas, supra note 68, at 119.

\textsuperscript{90} See id., discussing Section 2.02 of the Model Penal Code.

\textsuperscript{91} Id.

\textsuperscript{92} Id. at 109.
III. THE "TERMINALLY ILL" V. OTHERS WHO CONSIDER THEIR ILLNESSES OR DISABILITIES UNENDURABLE

Although the Compassion in Dying majority recognized that "the state has a legitimate interest in preventing suicides in general,"93 the court quickly added:

[That interest, like the state's interest in preserving life is substantially diminished in the case of terminally ill, competent adults who wish to die. One of the heartaches of suicide is the senseless loss of a life ended prematurely. In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early. Unlike...many others who may be inclined to commit suicide, a terminally ill competent adult cannot be cured.94

There is, of course, a substantial difference between terminally ill patients who commit suicide to avoid further pain and loss of dignity and individuals who commit what the Ninth Circuit calls "senseless" suicides. There is, however, a great deal of distance in between, that is to say, there are many suicides committed by individuals who are neither mentally ill nor terminally ill that can hardly be called "senseless." As one proponent of assisted suicide has observed, "[s]urely under a variety of circumstances life may be unendurable to a reasonable person, even though he does not face the prospect of immediate and painful death."95 As indicated by the survey of ancient attitudes toward the practice undertaken by the Compassion in Dying court, suicide has been deemed a rational and sensible act if, among other things, it is caused by "weariness of life," "fear of dishonor," if "your existence is hateful to you," or "if you are overwhelmed by fate" or "bowed with grief."96

93. Compassion in Dying, 79 F.3d at 820.
94. Id. at 820-21.
95. Alan Sullivan, A Constitutional Right to Suicide, SUICIDE: THE PHILOSOPHICAL ISSUES 229, 241 (Margaret Battin & David Mayo eds. 1980). Consider, too, Johnson, supra note 33, at 8:151: "Many of the most compelling cases of human suffering are not the terminal cases but the cases of chronic illness." See also Bouvia, quoted supra in note 33.
96. See Compassion in Dying, 79 F.3d at 806-07. See also People v. Kevorkian, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Dec. 13, 1993) (Kaufman, J.). The court in Kevorkian quoted philosopher Richard Brandt to the effect that among the reasons for ending life, in addition to serious illness, that "various writers have regarded as good and sufficient reasons," are events which make one feel ashamed, cause one loss of prestige and status, reduce one from affluence to poverty, cause loss of a loved one, cause "loss of a limb or physical beauty" and cause "the loss of sexual capacity." Kevorkian, No. 93-11482, 1993 WL 603212 (quoting Richard Brandt, The Rationality of Suicide, SUICIDE: THE PHILOSOPHICAL ISSUES 117, 123 (Margaret Battin & David Mayo eds. 1980). Judge Kaufman, whose opinion is discussed at length in Kamisar, supra note 83, at 239-44, was apparently the first American judge to hold squarely that there is a constitutional right to
The Compassion in Dying majority might respond by finding refuge in the concept of "terminal illness." Although "there is, in fact, no consensus on what is a 'terminal condition,'" it is frequently defined as a condition or illness that will result in death "imminently," "within a short time," or in six months. Unlike others who may wish to commit suicide, "a terminally ill competent adult cannot be cured."

The same may be said, however, for many nonterminal conditions or illnesses. The condition of a quadriplegic or multiple amputee is "incurable" and "irreversible," but such an individual may still have a long life expectancy. Additionally, the same may be true for a person afflicted with cerebral palsy (for example, Elizabeth Bouvia, the subject of one of the best known "right to die" cases), or someone in the early stages of Alzheimer's disease, who anticipates and fears mental deterioration in the years ahead (for example, Janet Adkins, Dr. Jack Kevorkian's first "suicide patient").


97. Thomas Marzen, Out, Out Brief Candle: Constitutionally Prescribed Suicide for the Terminally Ill, 21 HASTINGS CONST. L.Q. 799, 814 (1994). "This is testified to," adds Marzen, "by the variety of definitions found in state 'living will' laws." For a discussion of these various definitions, see 2 Alan Meisel, THE RIGHT TO DIE §11.0 (2d ed. 1995). See also Daniel Callahan & Margot White, The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village, 30 U. RICH. L. REV. 1, 45 (1996) (stating that "there is little examination or study of what is meant by terminal illness, or how long this terminal period of care lasts, and what factors are associated with or determine the difference in care and their duration.")

98. See Callahan & White, supra note 97, at 44; Yale Kamisar, When Is There a Constitutional "Right to Die"? When Is There No Constitutional "Right to Live"?, 25 GA. L. REV. 1203, 1210-11 (1991). However, according to Callahan & White, supra, at 45, "[t]he few studies that have been done indicate that the designation of six months as a terminal period is entirely arbitrary and that physicians vary drastically in their interpretation of what constitutes this terminal phase of illness."

99. See text supra at note 94.

100. See, e.g., McKay v. Bergstedt, 801 P. 2d 617 (Nov. 1990). Kenneth Bergstedt was a 31-year-old mentally competent quadriplegic who was dependent upon a ventilator to breathe. Bergstedt's condition was irreversible," but the trial court found he could live an additional 15-20 years. The state court held that although he was not terminally ill, Bergstedt had a right to discontinue the life support system that was keeping him alive. On the basis of Quill, a quadriplegic not dependent on life support could argue persuasively that to deny him the right to obtain a physician's assistance in committing suicide would be to deny him equal protection. See text supra at notes 33, 34.


In previous writings on this subject, this author has assumed that it is neither very difficult to define "terminal illness" nor very difficult to identify those who fall within this category. The author has also argued that if courts find or establish a right to determine the time and manner of one's death, a right that includes the active intervention of another to promote or to bring about death, such a right should not and will not (and probably cannot) be limited to the terminally ill. This article also assumes that a "terminal illness" is a manageable classification.

It should be noted, however, that Professor Joanne Lynn and five co-authors have launched a heavy empirical attack on the "terminally ill" classification, an attack so forceful that it should jolt any conscientious judge otherwise inclined to establish a right to assisted suicide "limited" to this group. Using data from SUPPORT (the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), a five-hospital study of treatment and decision-making for seriously-ill patients which provides "the largest available source of empirical data on prognosis that might be applied to defining terminal illness in various settings and various diseases," these six medical doctors and health professionals conclude:

Deciding what should count as "terminally ill" will pose such severe difficulties that it seems untenable as a criterion for permitting physician-assisted suicide. Allowing physicians (or anybody else) to decide who is terminally ill without any standards or guidance will result in uneven application with unjustified variations across diseases, across physicians, and across regions.

... Any [statistical] threshold is arbitrary and will incur a large number of ambiguous cases, both because many prognoses are unavoidably ambiguous and because the data are not available for many groups of dying persons. Furthermore, a restrictive threshold will limit availability to a small proportion of those who die, many of whom will be incompetent. It will also exclude almost all of some commonplace causes of death. Conversely, a more inclusive threshold will entail allowing physician-assisted suicide for a substantial number of persons who are otherwise destined to survive for an extended period.

103. See Kamisar, supra note 15, at 32, 36, 37.
105. Id. at .
106. See also Marzen, supra note 97, at 814-19. Although Marzen, General Counsel of the National Legal Center for the Medically Dependent and Disabled, did not have the benefit of the large amount of empirical data available to Professor Lynn and her co-authors, two and a half years ago Marzen also concluded that the term "terminal condition" was "too nebulous" to "provide any critical distinction" between those activities which are constitutionally protected and those that are not. Marzen, supra note 97, at 803. "Inherently vague and arbitrary criteria," maintained Marzen, "must necessarily be
Evidently unaware of the tremendous difficulties involved in determining who should be classified as "terminally ill" (as was this author before reading Joanne Lynn's article), the lawyers who unsuccessfully challenged the Michigan prohibition against assisted suicide and who successfully attacked the Washington and New York bans (and the federal courts who agreed with them) narrowly framed the issue by focusing on the "terminally ill": Insofar as a statute totally banning assisted suicide prevents physicians from providing life-ending medication for use by terminally ill, competent adults who wish to commit suicide, does it violate the Due Process Clause or the Equal Protection Clause? The fact that proponents of a constitutional right to assisted suicide (or of legislation permitting such a practice) would promote such a right only for the terminally ill (at least for now and the near future) is quite understandable. Such a narrowly tailored right causes less alarm and commands more support than would a right defined more broadly. Such a narrowly limited right indeed appears as only a very slight deviation from our social norms.

Once such a right is established, how long would it remain confined to the terminally ill? Is drawing a line between the terminally ill and other seriously ill or disabled persons (who may

---

built into any definition of 'terminal condition' that employs time-based elements, the fulfillment of which cannot in any case be predicted with any exactitude." Id. at 818.

See also Margot White & Marc Spindelman, Ninth Circuit Ignores Medical Experience at Our Peril, 2 BioLAW S:159, S:165 (Special Section, July-Aug. 1996): "[W]hat the [Compassion majority] has not addressed is the difference between 'terminal illness' used as a legal construct and 'terminal illness' used as a medical construct. . . . 'Terminality' — the idea that someone has a limited amount of time left to live — is, according to practicing physicians, a descriptive statement subject to interpretations that vary considerably from physician to physician."

107. See Kamisar, supra note 103, at 36-37.

108. Callahan & White, supra note 97, at 44. Callahan and White examined bills authorizing some form of physician-assisted suicide that were pending as of June 1995 in twelve state legislatures. Id. They found that the most common restriction was limiting eligibility to those who are "terminally ill." Id. at 44. A "model state act" drafted by Professor Charles Baron and eight co-authors, however, authorizes physician-assisted suicide for those "suffer[ing] from a terminal illness or from a bodily illness that is intractable and unbearable." (Emphasis added.) See Baron et al., supra note 58, at 25. "Intractable and unbearable illness" is defined as "a bodily disorder (1) that cannot be cured or successfully palliated and (2) that causes such severe suffering that a patient prefers death." Id. See also id. at 10-11.

109. As the authors of a model state act to authorize and regulate physician-assisted suicide have noted, terminally ill patients "have generally been seen as the least controversial candidates for the recognition of the right to die." Baron et al., supra note 58, at 10 n.39. A "bare majority" of the nine co-authors, however, concerned about nonterminally ill patients who are suffering greatly from AIDS, advanced emphysema, multiple sclerosis and other debilitating conditions, "agreed to allow anyone to be eligible whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death." Id. at 11.
have to endure more pain or suffering or indignity for a much longer period) either sensible or principled? Recall the arguments commonly made in behalf of assisted suicide for the terminally ill: The right should be grounded on self-determination, personal autonomy in matters involving one's most intimate choices, mastery over one's own life and body, and freedom from pain or suffering or indignity. Does not the strong rhetoric on behalf of a right to assisted suicide outrun its modest conclusion—assisted suicide only for the terminally ill?

Must a judge put on blinders and decide the “narrow” question presented without thinking about the consequences and ramifications of a “narrow” holding in favor of a right to assisted suicide? Is this how society wants judges to decide constitutional questions?

A court must decide the case before it, but as Justice Felix Frankfurter once observed, this “does not mean that a case is dissociated from the past and unrelated to the future.”110 The fact that the court must decide the case before it also does not mean that the case should be decided without “due regard for what went on before” and without equal regard “for what may come after.”111

John Arras’s remarks concerning the individuals who urge legislation to decriminalize assisted suicide, outlined below, applies as well to the individuals who advocate a constitutional right to assisted suicide:

[They] usually begin with a wholesomely modest policy agenda, limiting their suggested reforms to a narrow and highly specified range of potential candidates and practices. . . . But the logic of the case for PAS, based as it is upon the twin pillars of patient autonomy and mercy, makes it highly unlikely that society could stop with this modest proposal once it has ventured out on the slope. . . . [I]f autonomy is the prime consideration, then additional constraints based upon terminal illness and/or unbearable pain would appear hard to justify. Indeed, if autonomy is crucial, the requirement of unbearable suffering would appear to be entirely subjective. Who is to say—other than the patient herself—how much suffering is too much? Likewise, the requirement of terminal illness seems an arbitrary standard against which to judge patients' own subjective evaluation of their quality of life. If my life is no longer worth living, why should a terminally ill cancer patient be granted PAS but not me, merely because my suffering is due to my “nonterminal” ALS (amyotrophic

111. Id.
lateral sclerosis, or Lou Gehrig's disease) or intractable psychiatric disorder?\textsuperscript{112}

Both the federal district court and the Ninth Circuit in \textit{Compassion in Dying} supported their finding of a constitutional right to physician-assisted suicide in the capacious language of one portion of the \textit{Casey} opinion.\textsuperscript{113} To place the language of \textit{Casey} into some context, the entire paragraph in which the pertinent language appears reads as follows:

Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the \textit{individual}, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." \textit{These matters}, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the State.\textsuperscript{114}

Viewed in isolation and applied literally, \textit{Casey}'s lofty, almost breathtaking language seems to cover assisted suicide (and euthanasia as well). The same may be said, however, of Cardozo's oft-quoted remark that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."\textsuperscript{115} Does anybody really believe, however, that when Justice Cardozo's statement was uttered in 1914 that he meant, or anybody interpreted him to mean, that every person of adult years and sound mind has the right to obtain another's help in committing suicide or the right or liberty to authorize euthanasia?\textsuperscript{116}


\textsuperscript{113} See \textit{Compassion in Dying}, 850 F. Supp. at 1459-61 (quoting from the passage set forth \textit{infra} in text at note 114); \textit{Compassion in Dying}, 79 F.3d at 801, 813 (quoting from the passage set forth \textit{infra} at note 114.

\textsuperscript{114} Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992) (citations omitted; second emphasis added.)

\textsuperscript{115} Schloendorff v. Society of New York City Hosp., 105 N.E. 92 (1914).

\textsuperscript{116} Indeed, taken literally, Cardozo's statement would mean that a person of adult years and sound mind could sell his or her heart or other vital organs for a princely sum and arrange to have the proceeds given to the person's favorite grandchild. It would also mean that a person of adult years and sound mind who is dying of a brain tumor could
This author has maintained elsewhere that the "most intimate and personal choices," "choices central to personal dignity and autonomy," and "defin[ing] one's own concept of existence" language contained in the *Casey* opinion should be read as an explanation of why "personal decisions relating to marriage, prosecution, contraception" and "family relationships" have been given constitutional protection in previous cases.\textsuperscript{117} This author has also contended that the *Casey* Court, relying heavily on the rule of *stare decisis*, "was bent on bringing an old constitutional war to an end — not preparing to fight a new one."\textsuperscript{118}

Assume, however, that this author has given the aforementioned *Casey* language too begrudging a reading and that it does apply to assisted suicide. If so, there is no hint or suggestion in the language that a right to assisted suicide is available only to the terminally ill. If the right does exist, why should it be (how can it be) limited to the terminally ill?

Restating the *Casey* language, Professor Robert Sedler, who led the constitutional assault on Michigan's total ban against assisted suicide, maintains that "the right to define one's own concept of existence and to make the most basic decisions about bodily integrity surely must include the right of terminally ill persons to make the choice whether to hasten inevitable death or whether to go on living until death comes naturally."\textsuperscript{119} If, however, the *Casey* language does apply to suicide and suicide assistance, why should only a few people be allowed to define their own concept of existence? Furthermore, why should only a small fraction of the population be permitted to exercise a right that is purported to be "at the heart of liberty?"

If "the choice whether to hasten death or whether to go on living until death comes naturally" is a choice "central to personal dignity and autonomy" and "central to the liberty protected by the Fourteenth Amendment,"\textsuperscript{120} then to borrow a phrase from Cardozo, why doesn't every "human being of adult years and sound mind" have the right to choose?

The Second Circuit asked, "[w]hat business is it of the state to require the continuation of agony when the result [death] is

\textsuperscript{117}Kamisar, supra note 112, at 765-68.

\textsuperscript{118}Id. at 768.


\textsuperscript{120}See language from *Casey* in text supra at note 114.
imminent and inevitable?" What business is it of the state, one might add, to require the continuation of agony when death is not imminent, but the person seeking suicide assistance is of the firm belief that continued suffering is worse than death? Additionally, if it is "the state's business" to thwart the wishes of a person who seeks the assistance of a physician to commit suicide when that person is a quadriplegic with many years to live (or many years of what that person considers to be unacceptable agony), or in the early stages of Alzheimer's, why is it not also "the state's business" when the person is terminally ill?

States obviously have a strong interest in assuring that a request for suicide assistance is competent, informed, voluntary and enduring. Assuming, however, that a non terminally ill person meets these requirements, and indeed satisfies the most heightened evidentiary standard in this regard, why should the state's general interest in life override the individual's wishes, ignore the individual's values and deprive the individual of the right to define his or her "own concept of existence?" If it should, why should it not also override the wishes of the terminally ill patient? Indeed, a person in the terminal stages of AIDS or Alzheimer's disease or some other debilitating condition is more likely to have impaired decision-making capacity than one in the early stages of such diseases.

As the Compassion in Dying majority observed, the recognition that a person has a constitutionally-protected liberty interest in determining the time and manner of his or her death does not end a court's inquiry; this liberty interest "must be weighed against the state's legitimate and countervailing interests, especially those that relate to the preservation of human life." According to the Ninth Circuit, the state's interest in preserving life (and its legitimate interest in preventing suicide in general) is "substantially diminished in the case of terminally ill, competent individuals who wish to die."

"Substantially diminished" as opposed to whom? As opposed to those whose decision to commit suicide is "senseless?" The answer to this question is yes. As opposed to those would-be

121. Quill, 80 F.3d at 730.
122. See Baron et al., supra note 58, at 17-18.
123. Cf. Quill, 80 F.3d at 730. The court in Quill noted: "What concern prompts the state to interfere with a mentally competent patient's 'right to define his own concept of existence, of meaning, of the universe, and of the mystery of human life' when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness?" Id. at 730 (quoting Casey, 505 U.S. 833).
124. Compassion in Dying, 79 F.3d at 793.
125. Id. at 820.
126. See id. at 820-21.
suicides who "can be restored to a state of physical mental well-being?" Again, the answer is yes. As opposed, however, to those who cannot be restored to a state of physical and mental well-being, such as nonterminally ill people who are seriously disabled or suffering from a degenerative disease and who have reached the conclusion that their lives are so miserably restricted and meaningless that they are no longer worth living? The answer to this question would seem to be no.

Moreover, a balancing test is being applied, "weighing the individual's liberty interests against the relevant state interest in order to determine whether the state's actions are constitutionally permissible." As a result, the strength of the individual's interests as well as the state's must be considered. A forceful argument can be made that because a quadriplegic who could live another twenty years, but who views life as miserable and meaningless; or a victim of Alzheimer's disease who has ten years more to live but feels his or her deteriorating life is hopeless and empty, must suffer much longer than someone who only has two or three months (or two or three weeks) to live, these nonterminally ill persons have a stronger liberty interest in determining the time and manner of their deaths than do terminally ill patients.

As Professor Howard Brody recently observed:

Anecdotal case reports of patients seeking suicide assistance have so far suggested two general categories. One group is terminally ill and suffering from symptoms unrelievable by other medical means. The second group, generally suffering from degenerative neurologic disease, is mentally competent, greatly debilitated, but not terminally ill in any strict sense. For the first group, it is because they are so near death that continued life with suffering lacks real meaning for them. For the second group, it is precisely because the fact that death is so far away, and they have to face years of existence unable to perform any functions that give life quality or meaning for them, that seems to make assisted suicide a rational option."

At one point, the Ninth Circuit observed:

127. Id. at 821.
128. Id. at 799.
129. Brody, supra note 75, at S:157-S:158. See also Marzen, supra note 97, at 800; Wennberg, supra note 112 at 99. Dr. Brody thought it "of some interest" that the Ninth Circuit restricted the right to physician-assisted suicide to the terminally ill, "mak[ing] no mention whatever of the needs of this second category." Brody, supra, at S:158. "Admittedly," added Brody, "the petition of Compassion in Dying was restricted to physician-assisted suicide for the terminally ill, competent patient," but "that restriction did not prevent the court from alluding both to active euthanasia and to suicide assistance via proxy for the incompetent." Id.
When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state’s interest in forcing them to remain alive is clearly less compelling.\(^{130}\)

Although when it made that statement the *Compassion in Dying* majority probably had the terminally ill in mind, as written the statement about those who “do not wish to pursue life” is not limited to the terminally ill. As written, the category includes the nonterminally ill persons who Dr. Brody and this author have in mind: quadriplegics, amputees or others who are severely and permanently disabled, persons in the early stages of Alzheimer’s disease or those suffering from other “incurable” but nonterminal illness. Some of these people, too, have reached the sad but firm conclusion that because they can no longer experience a sufficient degree of “liberty or happiness,” they no longer “wish to pursue life.”

If, as seems to be the case, personal autonomy (or self-determination) and the termination of suffering are the driving forces behind the right to, or liberty interest in, physician-assisted suicide, it is not easy to see why a person who (a) has made a voluntary, informed decision to die by this practice; (b) has a persistent wish to do so; and (c) is suffering from a non-terminally ill condition that he or she finds unendurable\(^{131}\) should be denied the assistance that he or she seeks because the person does not “qualify” based on a court’s “balancing of interests” test.

Consider the various positions taken by Robert Sedler, a civil liberties lawyer who has advocated a constitutional right to physician-assisted suicide and a law professor who has written several articles on the subject. At times, Professor Sedler has expressed the view that this constitutional right should be confined to the terminally ill.\(^{132}\) At other times, he has indicated that the right should extend to non-terminally ill persons “who are so debilitated that for them life has become unendurable.”\(^{133}\) Professor Sedler has expressed at still other times the view that whether a non-terminally ill patient may avail himself or herself

\(^{130}\) *Compassion in Dying*, 79 F.3d at 820.

\(^{131}\) Under the “Model State Act” drafted by Professor Charles Baron and eight others, anyone “qualifies” whose illness is terminal or “whose illness is incurable and who subjectively feels that the accompanying suffering is worse than death.” Baron et al., *supra* note 58, at 11. The authors “rejected a more objective definition of the patient’s suffering” largely because they “realized that whether one’s suffering is sufficiently unbearable to make death preferable to continued life is an inherently subjective determination on which people differ, and for which no objective standard should be imposed on everyone.” *Id.*


of this right "requires constitutional balancing."\textsuperscript{134} He tells us, for example, that if a victim of multiple sclerosis were not terminally ill but severely debilitated by the disease, and wished to die by physician-assisted suicide, the state’s interest in preserving life is “not likely” to outweigh “the interest of the multiple sclerosis victim in ending a life that has become unendurable.”\textsuperscript{135}

If the Supreme Court establishes a right to physician-assisted suicide for the terminally ill, how are the lower courts (and perhaps the High Court itself) going to address each claim by a non-terminally ill patient that life has become unbearable? Should courts address the claim by balancing the state’s asserted preservation-of-life interest against the patient’s competing liberty interest, perhaps one disease at a time? Or, as Professor Sedler also suggests,\textsuperscript{136} are the courts going to resolve these matters by determining whether the claim of a non-terminally ill person seeking physician-assisted suicide is “objectively reasonable?”

A final comment on the scope of a right to physician-assisted suicide is necessary. If either the \textit{Compassion in Dying} or \textit{Quill} rationale is upheld by the U.S. Supreme Court, it is hard to see how the right to physician-assisted suicide could be limited to the terminally ill for very long. Both Circuit Courts proceeded on the premise that there is no significant difference for constitutional or ethical purposes between the new right to assisted suicide and the well-settled right to reject life-sustaining medical treatment.\textsuperscript{137} Indeed, the Second Circuit went so far as to say that to permit terminally ill patients on life support to terminate such support, but to forbid terminally ill patients off life support to obtain a physician’s assistance in committing suicide is to deny “similarly situated” terminally ill persons, except for the fact that they are not attached to life support systems, the equal protection of the laws.\textsuperscript{138}

The right to reject life-sustaining treatment, however, has not been limited to the terminally ill. Indeed, “the right of a competent person to refuse medical treatment is virtually absolute.”\textsuperscript{139} If so, and if there is no significant distinction between rejecting life-sustaining treatment and physician-assisted suicide, how can the latter right be limited to the terminally ill?

Moreover, if the Second Circuit’s Equal Protection analysis is sound, are not people suffering from the same non-terminal ill-

\begin{enumerate}
\item See id. at 792.
\item See id. at 792-93.
\item See id. at 792, 794.
\item See text supra at notes 19, 22-28.
\item See text supra at notes 24-27.
\item See supra note 33 and accompanying text.
\end{enumerate}
nesses or diseases "similarly situated" regardless of whether they are on or off life support? If so, and if non-terminally ill patients on life support can terminate such support but "similarly situated" patients, except for being attached to life-sustaining medical equipment, do not have the same right to determine the time and manner of their deaths by obtaining the assistance of a physician in committing suicide, are not the "similarly situated" nonterminally ill patients off life support being denied equal protection?

IV. PHYSICIAN-ASSISTED SUICIDE V. ACTIVE VOLUNTARY EUTHANASIA

As Joseph Fletcher has noted, "it is impossible to separate active voluntary euthanasia from suicide; it is indeed a form of suicide [and the case for active voluntary euthanasia] depends upon the case for the righteousness of suicide. Raanan Gillon has also aptly stated that, "[v]oluntary euthanasia is essentially a form of suicide, involving the assistance of others." Additionally, James Rachels has asserted:

[I]f it is all right for a person to bring about a certain situation, then it is all right for that person to enlist the freely given help of others in bringing it about. . .In this way the permissibility of euthanasia follows from the permissibility of suicide — a result that will not surprise any thoughtful person.

As previously discussed, the Quill court seemed quite willing to respect the distinction between physician-assisted suicide and active voluntary euthanasia. This is not true, however, of the Compassion in Dying majority. Although the Compassion in Dying majority noted that whether there was a constitutional

140. JOSEPH FLETCHER, MORAALS AND MEDICINE 176 (1954). Fletcher, a famous medical ethicist, was a long-time advocate of the legalization of active voluntary euthanasia.
142. JAMES RACHELS, THE END OF LIFE: EUTHANASIA AND MORALITY 86-87 (1986). The fact that neither suicide nor attempted suicide is still a crime in this country does not mean, as Professor Rachels seems to think, that society considers it "all right" for a person to commit suicide. Suicide and attempted suicide were decriminalized not because society approved of these acts but because there was no form of punishment acceptable for a completed suicide nor any that seemed appropriate for someone who had attempted suicide (and was deemed in greater need of medical or psychiatric attention than criminal punishment). Those individuals who aid or assist another to commit suicide are still considered to be within the reach of the criminal law on the ground that their behavior can be influenced by the law. See generally Thomas Marzen et al., Suicide: A Constitutional Right?, 24 DUQUESNE L. REV. 1, 68-100 (1985). See also Yale Kamisar, Are Laws Against Assisted Suicide Unconstitutional?, 23 HASTINGS CENTER REP., May-June 1993, at 32-33.
143. See supra note 36 and accompanying text. The Quill court noted that "euthanasia falls within the definition of murder." Id.
right to, or liberty interest in, active voluntary euthanasia as well as in physician-assisted suicide was a question that had to be answered in a future case, the majority could not resist suggesting how the question would be resolved. The court stated:

We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. . . . We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end.144

Those individuals who favor the legalization of active voluntary euthanasia at some point down the road must have had a mixed reaction to the Compassion in Dying majority's comments. On the one hand, the court did indicate that the two practices are essentially the same because, for example, both practices provide the same benefits and generate the same concerns about abuse. As Dan Brock, a leading proponent of both physician-assisted suicide and active voluntary euthanasia has maintained:

In both [assisted suicide and voluntary euthanasia], the choice rests fully with the patient. In both [cases] the patient acts last in the sense of the right to change his or her mind until the point at which the lethal process becomes irreversible. . . . If there is no significant, intrinsic moral difference between the two, it is difficult to see why public policy should permit one but not the other; worries about abuse or about giving anyone dominion over the lives of others apply equally well to either.145

On the other hand, since assisted suicide is less widely (and less severely) condemned by the criminal law, is regarded as a slighter deviation from our social norms than active euthanasia, and is seen as offering more protection against potential abuse than active euthanasia, "since the final act is in the patient's hands,"146 physician-assisted suicide causes less alarm than active voluntary euthanasia and commands more support.147

144. Compassion in Dying, 79 F.3d at 831-32. Of course, in the case of voluntary euthanasia, as well as in assisted suicide, the terminally ill person personally determines whether his or her life shall end.


146. Herbert Hendin, Seduced by Death 34 (1997). Dr. Hendin goes on, however, to say that opponents of physician-assisted suicide, of which he is one, "see little protection in assisted suicide: people who are helpless or seriously ill are vulnerable to influence or coercion by physicians or relatives who can achieve the same results whether or not they participate in the patient's death." Id.

147. According to Herbert Hendin, the Executive Director of the American Suicide Foundation, who has published a new book on the practice of physician-assisted suicide and active voluntary euthanasia in the Netherlands, in the summer of 1995 when "there was sharp criticism of Dutch euthanasia policies throughout Europe and even in the Netherlands," the KNMG (the Royal Dutch Medical Association), "in an effort at damage
Professor Brock's argument for legalizing some form of active euthanasia may be quite powerful once assisted suicide is established, once a considerable number of states legalize physician-assisted suicide or the Supreme Court affords the practice constitutional protection. The trouble is, however, that these events have not yet occurred.

Proponents of both physician-assisted suicide and active voluntary euthanasia who are well aware that "euthanasia" is a term that has "strong emotionally laden connotations" may believe that at this point in the development of the law and ethics governing death and dying, the less talk about euthanasia the better. Proponents may fear, understandably, that few legislatures are likely to authorize physician-assisted suicide and the Supreme Court is unlikely to give it constitutional status if it is linked to active voluntary euthanasia "before its time."

Surely this explains in part why the nine physicians, lawyers and ethicists who drafted a "Model State Act" authorizing and regulating physician-assisted suicide and who wrote an accompanying article did not address active voluntary euthanasia. "Members of the public and the medical community disagree," they observed, "and we disagree among ourselves," they added, "as to whether there is an important difference between the two concepts." Although Professor Baron and his eight co-authors did stop short of recommending the legalization of active voluntary euthanasia, these nine individuals did not disapprove the practice.

As this author has discussed elsewhere at some length, an individual who looks at the media's treatment of the so-called right to die or even the professional literature on the same subject soon discovers that the line between physician-assisted suicide and active voluntary euthanasia is usually blurred and sometimes obliterated. Moreover, the emergence of such phrases as "aid-in-dying" and "physician-assisted death," which are terms which cover both physician-assisted suicide and active vol-


150. Id. at 10.

151. See Yale Kamisar, Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia, EUTHANASIA EXAMINED 225, 230-33 (John Keown ed. 1995); Kamisar, supra note 141, at 32.
untary euthanasia, have further smudged the distinction between the two practices.

The distinction between physician-assisted suicide and active voluntary euthanasia is difficult to maintain in practice and even harder to defend as a matter of principle. The Compassion in Dying majority did not try to defend the distinction, rather it "agree[d] that it may be difficult to make a principled distinction" between physician-assisted suicide and active voluntary euthanasia. The court "recognize[d] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under the direction or control may be the only way the patient may be able to receive them." How can this distinction be defended? If the claim that a terminally (or seriously) ill person has a right to control the time and manner of his or her death is well founded, how can this right be denied an individual who otherwise "qualifies" simply because this individual cannot swallow the barbiturates that will bring about his or her death?

Is not the case for active voluntary euthanasia essentially the same as the case for physician-assisted suicide? If a patient's inability to commit suicide "for either physiological or psychological reasons" is supposed to entitle the patient under certain circumstances to a physician's assistance in bringing about the patient's desired suicide why should a patient's inability, despite the preliminary assistance of a physician to bring about the desired death (because, for either physiological or psychological reasons, the patient is unable to personally perform the last, death-causing act) not entitle the patient to active voluntary euthanasia? If physician-assisted suicide is appropriate when


153. Consider the following: A competent person who has resolved to die by suicide and made this wish clear accomplishes his or her purpose by swallowing a lethal dose of medication which the physician has placed (a) on the night stand next to the person's bed, (b) in the person's hand, (c) in the person's mouth. Has the physician committed murder (which is how active voluntary euthanasia is currently regarded) or has the physician assisted in a patient's suicide? Compare Lawrence O. Gostin, Drawing a Line between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying, 21 J.L. MED. & ETHICS 94, 96 (1993) with Kamisar, supra note 151, at 230-31.

154. Compassion in Dying, 79 F.3d at 831.

155. Id.

patients need more help from a physician than merely terminat-
ing life-sustaining treatment, why is active voluntary euthana-
sia not appropriate when patients need more help than a supply
of lethal medicine, or when nothing less than a lethal injection
will suffice to enable them to effectuate their choice to “hasten
their death”?

Until recently, Dr. Timothy Quill and Dr. Diane Meier would
have disagreed with this author. In 1992, Quill and Meier
announced their support for physician-assisted suicide (under
certain conditions), but balked at active voluntary euthanasia.
Although Quill and Meier recognized that excluding active vol-
untary euthanasia from “a continuum of options for comfort care”
occurring at “a cost to competent, incurably ill patients who cannot
swallow or move, and who therefore cannot be helped to die by
assisted suicide,” they opposed legalizing any form of active
euthanasia “because of the risk of abuse it presents.” Access to
medical care in this country, Quill and Meier pointed out, “is cur-
rently too inequitable, and many doctor-patient relationships too
impersonal, for us to tolerate the risks of permitting active volun-
tary euthanasia.”

This author’s first reaction to these comments was the follow-
ing: Why can’t the very same thing be said about not tolerating
the risks of permitting assisted suicide? Shouldn’t society either
legalize both assisted suicide and active euthanasia or continue
to prohibit both practices?

After reading the comments Quill and Meier made in 1992, it
also struck this author that their approach to active voluntary
euthanasia was not very different from this author’s approach to
physician-assisted suicide and active voluntary euthanasia.
With respect to assisted suicide, Quill and Meier were what

157. See id.

158. Timothy E. Quill et al., Sounding Board: Care of the Hopelessly Ill — Proposed

159. Id. at 1381.

160. Id. According to Dr. Quill and his co-authors, because in assisted suicide “the
final act is solely the patient’s,” and thus “the risk of subtle coercion from doctors, family
members, institutions, or other social forces is greatly reduced,” the “balance of power
between doctor and patient is more nearly equal in physician-assisted suicide than in
euthanasia.” Id. But this argument is sharply disputed by Daniel Callahan & Margo
White, The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin
Village, 30 U. Rich. L. Rev. 1, 6-7 (1996), who maintain that the “power differential”
between physicians and patients is essentially the same in both cases. See also Hendin,
supra note 146. In any event, the view held by Quill and Meier in 1992 that the “balance
of power” between physician and patient was more nearly equal in assisted suicide than
in euthanasia did not keep them from crossing the line between assisted suicide and
euthanasia two years later. See infra note 162 and accompanying text.

161. Quill et al., supra note 158, at 1381.
might be called “act utilitarians” and this author was what might be called a “rule utilitarian” (one who does not believe that the beneficial consequences of individual acts are decisive when one makes public policy); but when it came to euthanasia, all of us, it seemed, were inclined to be “rule utilitarians.”

This, however, was in 1992. Two years later, both Dr. Quill and Dr. Meier became more consistent “act utilitarians.” They no longer defended an absolute prohibition against active euthanasia. Along with four other individuals, Quill and Meier co-authored an article maintaining that “physician-assisted death” should not be limited to assisted suicide. Rather, they advocated that under certain circumstances, physician-assisted death should also include active voluntary euthanasia:

To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.¹⁶²

The fact that two of the most thoughtful participants in the debate on death and dying once drew a distinct line between assisted suicide and active euthanasia, only to cross that line a short two years later, is further evidence that the distinction between physician-assisted suicide and physician-administered active voluntary euthanasia is too thin to endure for very long.

Unlike the Compassion in Dying Court, the Quill court did not suggest, in so many words, that it would be receptive to a claim by a person otherwise qualified for physician-assisted suicide that because the patient could not swallow a lethal dose of a medicine, the patient had a right to or liberty interest in active voluntary euthanasia. Quill’s Equal Protection analysis, however, speaks louder than its specific silence on this issue. If patients off life support are “similarly situated” to patients on such systems for purposes of controlling the time and manner of their death, then surely terminally ill patients who lack the ability to perform the last, death-causing act themselves, and thus need a physician to do it for them, are “similarly situated” to terminally ill patients who are able to perform the “last act” themselves.

In short, the Compassion in Dying court would probably “constitutionalize” active voluntary euthanasia in certain circumstances, and the Quill court’s Equal Protection analysis would all but compel it to do so as well; unless the court realized, on taking

a sober second look, that its original analysis could not withstand close scrutiny.

V. SOME FINAL REMARKS

Four years ago in an article that now seems prophetic, Sanford Kadish, a leading criminal law scholar, concluded that the distinction between forgoing life-sustaining treatment and what he called “conventional suicide and consensual euthanasia” could not withstand “principled analysis.”163 Professor Kadish makes a persuasive case (as do the Compassion in Dying and Quill courts).

As this author has tried to show, however, and as this author reads Professor Kadish’s article and believes he would agree,164 the distinction between assisted suicide and voluntary euthanasia and between terminally ill persons who wish to “hasten their deaths” by physician-assisted suicide and other competent, adult patients who have the same firm, persistent wish to do so (at least others who are seriously ill or permanently disabled) cannot withstand “principled analysis” either. Indeed, these distinctions can best be explained as matters of strategy.

Moreover, Kadish is quick to add:

I do not mean to suggest that the law cannot justifiably make distinctions on pragmatic grounds; it frequently does so for all kinds of prudential considerations. I mean only to suggest that the distinctions under discussion cannot be defended except on pragmatic grounds.

... It isn’t hard to surmise why courts have drawn back from the conclusion that there is no difference between suicide and refusal of treatment. To accept it would be to acknowledge a radical break with the received tradition and open the door to positions the courts are not yet willing to adopt: for example, that the state may not act to prevent suicide (except perhaps temporarily to assure competent consent), or to prevent a person from assisting another’s suicide, or conceivably even to prevent one person from killing another who competently consents to being killed. ...165

As Kadish indicates, there is a tension between the right to forgo life-sustaining treatment and the anti-suicide tradition. As the Cruzan Court pointed out, the “logical corollary” to the well-

163. Sanford Kadish, Letting Patients Die: Legal and Moral Reflections, 80 CALIF. L. REV. 857, 864, 868 (1992). Professor Kadish, inter alia, rejects the explanations or justifications often advanced to distinguish the removal of life support from physician-assisted suicide. As has been seen, however, at least two commentators who go on to defend the distinction on other grounds also reject these explanations and justifications. See supra notes 35-43 and accompanying text.
164. See Kadish, supra note 163, at 864, 869-70.
165. Id. at 867-88.
established doctrine of informed consent is "the right not to consent, that is to refuse treatment." The right to refuse treatment has carried a long way, but as Holmes once said, although "all rights tend to declare themselves absolute to their logical extreme," all rights are "limited by the neighborhood of principles of policy other than those on which the particular right is founded, and which become strong enough hold their own when a certain point is reached." The right to refuse treatment has come to mean the right to remove the feeding tube as well as the respirator. This right has also come to mean that one person can remove the life-support of an incompetent family member if there are grounds for a "substituted judgment" (or even, perhaps, if it is in the incompetent patient's "best interests"). Surely, however, when the right to refuse treatment becomes the basis for an alleged right to the active intervention of a physician to promote or to bring about death, the anti-suicide tradition is, to use Holmes' phrase, "strong enough to hold [its] own."

This author does not maintain that a legislature must reach this conclusion. If a legislature does do so, however, its judgment should not be overturned by the courts. As one leading proponent of physician-assisted suicide has recently observed:

Legalization of physician-assisted suicide should be understood not as a matter of recognizing rights but as a policy aimed at making available a compassionate option of last resort for competent, terminally ill patients. Since we do not know whether such a policy will produce more good than harm, it should be viewed as an experiment.

Our federal system of government has often been touted as offering "a laboratory of the states," with which to experiment concerning social policy. In the case of a morally controversial issue, subject to competing arguments pro and con, it is better that policy experimentation occur piecemeal, by the various decisions of the legislatures or voters of the states, rather than wholesale, by means of the constitutional adjudication of the federal courts. . . . If the Supreme Court overrules the ninth and second circuits by leaving the legality of physician-assisted suicide up to the states, this should not be viewed as a defeat by advocates of "death with dignity." Regardless of the ultimate judicial outcome, the Oregon referendum legalizing physician-assisted suicide is virtually certain to be imple-
mented. One or more states will likely follow suit. With competent evaluative research we will be in a position to deliberate whether this policy experiment proves to be a success.¹⁶⁹

Unless the principle of “self-determination” or “personal autonomy” or “control of one’s own destiny” or “the right to define one’s own concept of existence” is carried out to its ultimate logic, a line will have to be drawn somewhere short of assisted suicide and active voluntary euthanasia for any competent individual who firmly requests it for any reason the individual deems appropriate. Any intermediate line that is drawn, however, will be somewhat arbitrary.

In conclusion, using a quote from Holmes one last time:

Looked at by itself without regard to the necessity behind it the line or point seems arbitrary. . . .But when it is seen that a line or point there must be, and that there is no mathematical or logical way of fixing it precisely, the decision of the legislature must be accepted unless we can say that it is very wide of any reasonable mark.¹⁷⁰


¹⁷⁰. Louisville Gas & Electric C. v. Coleman, 277 U.S. 32, 41 (1928) (Holmes, J., dissenting). Cf. Planned Parenthood v. Casey, 505 U.S. 833, 870 (1992) (Opinion of O'Connor, Kennedy & Souter, JJ.), in which the following was noted: “Consistent with other constitutional norms, legislatures may draw lines which appear arbitrary. But courts may not. We must justify the lines we draw.” Id.